TREATING SELF-INJURY: A PRACTICAL GUIDE by Barent W. Walsh, New York: Guilford Press, 2006, xvi + 317 pp., $ 35.00

This is a clinician's guide, written by a clinician, not a professor, with over 25 years experience devoted to the topic. Walsh, Executive Director of The Bridge of Central Massachusetts, headquartered in Worcester, Massachusetts, comprising over 30 programs serving emotionally disturbed, mentally ill, or developmentally delayed children, adolescents, or adults has conducted research, written extensively, spoken internationally on self-injury. Walsh aims his book at professionals who treat individuals who self-injure, whether they represent those who have major mental illness, or represent the "new generation" of mentally healthier individuals who self-injure due to recent peer-led trends in this area. Walsh begins by defining self-injury, separating it from suicidal behaviors on the one hand, and tattooing and body piercing on the other, defining the populations most correlated with self-harm. Following his introductory sections Walsh describes "the heart of the book" which pertains to assessment and treatment, both behavioral and pharmacological. The last major section covers special topics, addressing contagion or epidemic self-injury, school prevention programs and understanding, treating and preventing major self-injury – acts that produce extensive tissue

damage and/or mutilation of the genitalia, face or eyes; behaviors typically associated with a comorbid significant mental illness.

Initially termed self-mutilation, self-injurious behaviors (SIB) include cutting (the most common), scratching, burning (either with heat or mechanical abrasion), hitting, purposeful picking and excoriation of existing wounds and hitting the self. Self-injurious behavior is seen by Walsh as more a maladaptive coping mechanism than a true attempt to self-hurt. The term self-mutilation, now seen as sensationalistic, now gives way to a more clinical, less inflammatory and denigrating term, enabling a clearer focus on the maladaptive psychological process used to reduce distress. Walsh makes a strong case to see self-injury as distinctly different from suicide and suicidal gestures, objecting to the term para-suicidal as being clinically wrong and leading to misunderstanding of the motive(s) behind these behaviors. Suicide is an attempt to escape permanently from pain whereas self-injury is an attempt to produce relief from unpleasant affect; to modify rather than terminate pain. Suicide often produces significant injury and death whereas most self-injury produces far less damage and is meant to be non-lethal. In suicidal patients, pain is seen as unending and unendurable, as contrasted with the intermittent discomfort reported by self-injurers. Self-injurers are often hopeful and optimistic, in stark contrast to suicidal patients who

typically present with hopelessness and helplessness. Self-injurers are bimodal in distribution regarding pain. Many seek relief from excesses in anger, shame, anxiety and frustration while some seek to enable the sensation of pain to combat feeling deadened. Feeling pain and seeing blood is strongly reinforcing as it makes contact with a sense of being alive and capable of feeling. Suicide is **presumed**, to be reinforcing in that it is hoped that it will end pain. Self-injury is **actually and immediately** reinforcing as it provides reduction of emotional distress. Self-injury is often associated with body image issues, body alienation and body self-hatred. Additionally, there is a group of psychologically more healthy individuals who self-injure presumably because they do not have more effective self-soothing skills. Peer influence is an added factor and in some cases over the last 10-15 years self-injury has become a "cult" phenomenon. Seeing compelling differences between those who self-injure and those who are prone to suicide, Walsh warns not to use terms linked to suicide, such as, gesture, attempt or parasuicide. Instead, he counsels to listen to patients' own language and mirror the terms used by that individual. Where the patient's terms are either overly dramatic or, conversely, underplay the severity of SIB, efforts are marshaled to be more descriptive and affectively more accurate. Walsh does not use "contracting for safety", an attempt at **stopping** behavior (and a standard process when dealing with suicidal patients) recommending

instead a self-protecting contract aimed at **reducing** SIB frequency. A sample of a self-protection contract is included together with sound clinical advice for therapists regarding not placing undue pressure on patients to stop their SIB behaviors and to not press for safety contracting too early before the patient is ready for such a commitment.

There are a few classificatory schemas for SIB. Stereotypic SIB is most closely related to Mental Retardation or related Pervasive Developmental Disorders. This is different from the type of SIB dealt with in this book, being biologically driven, occurring at very high rates and topographically fixed. Self-injury driven by psychosis is, likewise, not the focus of this book Walsh does provide resources for those readers interested in these types of self-injury. Behaviors, which indirectly place the person at risk of harm, such as, risk taking, sexual acting out, drunkenness, substance abuse, bulimia and medication discontinuation (surprisingly, Walsh does not include smoking in his exclusion list) are not included in the thrust of this text. Walsh delineates two types of SIB, common and major, which become the focus of this book.

The SIB population has a high component of individuals with significant mental illness. In addition to patients in outpatient therapy

are persons with persistent mental illness, patients in both short and long term psychiatric and forensic units, youth in special education residential facilities and in juvenile detention centers as well as prison inmates.

Walsh notes that an astonishing phenomenon occurred beginning in the late 1990 when a significant increase in SIB in apparently healthier individuals, from youth in middle school, High School age teens, young adults in college and adults in the general population began to present themselves for treatment. Ross and Heath (2002) studied 440 Canadian High School youths and found that almost 14 percent reported SIB. Two thirds of those admitting to SIB were girls. Of those who admitted to SIB, one out of eight reported some form of SIB on a daily basis while one out of three reported SIB more than once per week! Interviews with young self-injurers note that there is a high frequency of social contagion with friends introducing them to SIB. In college, most self-injurers were functioning well academically and were engaged in serious relationships. Feminists have explained the increased incidence of women who self-injure by seeing it as an extension of socially approved forms of self-injury such as ear piercing, eyebrow plucking, wearing of cinching, pinching and restrictive clothing, and the

societal reinforcement for plastic and cosmetic procedures such as facelifting and liposuction.

In his assessment of patients Walsh addresses five biopsychosocial factors including environmental, biological, cognitive, affective and behavioral influences. Linehan's (1993) work focusing on the "invalidating environment" that often represents the family background of many patients diagnosed with borderline personality disorder (BPD). However, the population of individuals with BPD in the population of individuals with SIB is not amplified. Walsh does discuss biological vulnerability, theories of Limbic system and Serotonin level dysfunction as well as dysfunction with Endogenous Opioids. A helpful chart is provided detailing the multi-dimensional aspects of Walsh's Biopsychosocial model, highlighting all sub-areas of his 5-factor system. Therapists' interpersonal skills and reactions are discussed, stressing the need for non-judgmental, empathic, attentive listening. Intense concern, effusive support, showing anguish or fear over the patients injury, recoiling with shock and avoidance and condemnation, ridicule or threatening the patient to desist and contract for safety are eschewed as therapeutically nonproductive and potentially damaging. Adopting a "respectful curiosity" and non-judgmental compassion coupled with a low-keyed dispassionate demeanor is suggested.

The chapters on assessment and treatment represent the clinical core of this book. A self-injury log is detailed in order to collect baseline frequencies for wounding behavior and wounding episodes. Assessing the extent of damage, pattern of injury, body area targeted and tools used to self-injure represent some of the data to be collected together with room or setting, social context, antecedents and immediate consequences. In tracking antecedents, therapists need to inspect interpersonal conflicts, pressure for deadlines, performance demands, frustrations and their causes, social isolation and any biological factors, such as depression, anxiety, emotional instability and dysregulation together with cravings to self-injure. Inquiring about diminished sensitivity to pain as well as a generalized feeling of lack of feeling are additional assessment variables together with the typical cognitive analysis of automatic thoughts, core beliefs and distorted ideation. A thorough review of consequences, both reinforcing events in the near term and later negative consequences, both emotional and physical, are to be recorded and discussed.

In keeping with the hierarchical potency of treatment options, once initial assessment is completed, contingency management is the first level of treatment suggested. While no therapy follows a linear

course, after contingency management replacement skill training is suggested. If SIB represents ineffective coping behavior, teaching more effective coping skills makes eminent sense. Even though such an approach seems logical, there is a dearth of supportive data as to its efficacy, in part due to research in this area being still in its infancy. Walsh lists nine areas of skills training focus. The first, termed "negative replacement skills" represents behaviors that are a topographical modification of SIB, such as coloring the skin with a marker pen, applying ointments such as Ben Gay which produce clear somatic sensations, writing about or dictating a detailed SIB sequence into a tape recorder, stimulating with area(s) typically abused with some soothing material, etc. These are controversial as they draw attention to the area of injury and are topographically similar to the behavior that is to be reduced. They can be too loaded with injury associations and may serve as discriminant stimuli to produce unwanted behavior. Safer replacement skills can be teaching of mindfulness breathing, visualization techniques, exercise, writing, artistic expression, playing to or listening to music, speaking with others as well as other diversion techniques. Helpful examples and data keeping logs are provided together with explanatory dialogue.

Cognitive treatment is the third aspect of Walsh's treatment package. He presents a reasonable overview of traditional cognitive-

behavior therapy (CBT). As in previous chapters, helpful figures, lists and graphs are included with narrative to enhance clarity. Missing in this chapter is any emphasis on positive practice or stressing the need for rehearsal of replacement cognitions. Also missing is reference to the newer mindfulness and acceptance literature. Walsh does include body image work and attention to sexual characteristics and behaviors that might be linked to body image and body integrity issues. The possible links of body integrity and body image issues to trauma is developed. Walsh offers the opinion that there is an inverse relationship between body image issues and positive prognosis. Importantly, Walsh provides an extensive set of examples of homework meant to cover many body image variables including attractiveness, physical effectiveness, health, sexual characteristics and behaviors and body integrity and sensate capacity.

Trauma is often associated with SIB. As trauma is often followed by post-traumatic symptoms, Walsh addresses exposure treatments for such problems, reviewing the process of information gathering, breathing retraining, psychoeducation, and exposure typically used with this population. Walsh integrates these exposure treatments with cognitive procedures for the typical distortions associated with trauma. Walsh also provides information on family treatments for all patients with SIB and information on what is

currently know regarding pharmacological management. He briefly notes the relevant brain regions implicated in SIB, the neurotransmitters suspected to influence such behaviors and the range of psychopharmacological agents that have shown some positive effect, providing an excellent decision tree reviewing the developmental context, associated psychiatric conditions, existential, social context and adaptive capacity of the patient to enhance outcome.

Since SIB can produce a strong negative visceral response in some therapists, Walsh presents information and advice aimed at managing the therapist reactions to such behaviors. He provides a quote from Alderman (1997, pg 192) detailing her personal upset, desire to protect and impulse to demand a promise of safety, common to many working in this area. Interestingly, Walsh's book is clinically presented with insufficient attention paid to the pain, anxiety and possible upset of either the patient or the therapist. In Alderman's one quoted paragraph, this key-missing variable is to briefly seen. Working with this population can be emotionally challenging for the therapist and the level of patient distress can be high. Any sense of angst and anguish is surgically removed in Walsh's straightforward clinical presentation. While the book presents the clinical aspects of

treatment well, it seems to fall somewhat short in addressing the gritty human issues and existential pain often encountered.

As mentioned earlier, a new group of younger individuals with less psychopathology has emerged over the last 10 years. Schools have become breeding grounds for SIB. Factors effecting individuals and groups, such as limited communication skills, attacks on the self in order to hurt others, coercion, attention seeking and shock are developed. Walsh presents information on this contagion and provides a protocol to deal with it. His book finishes with appendices including a breathing manual, a Body Attitude Scale, websites related to SIB, and what Walsh describes as a "Bill of Rights" for patients with SIB.

This is a thorough and comprehensive book on SIB reflecting many years of experience. It is clinical and workmanlike in presentation. In its attempt to be clinical, the pathos occasionally linked to this population is insufficiently addressed. Its impact on therapists would be enhanced if interpersonal issues were given additional attention. I am sure Walsh has provided valuable clinical supervision to therapists working in this area. I am likewise clear that much of what is important to discuss in supervision did not make its way into this book. This is a loss for us all. Similarly, the addition of

more recent treatments covering mindfulness and acceptance together with some increased focus on Dialectical Behavior Therapy would be a positive. As it is, the book has much merit. It would be beneficial reading for any advanced graduate course in behavior therapy, especially focusing on borderline personality and other difficult populations. Anyone dealing with a patient with SIB, or specializing in this population will find this book valuable in providing a basic overview of accepted treatment strategies as well as giving valuable advice regarding appropriate ways for the therapist to manage themselves when confronted with injury in their patients. $35.00 is good value. Integrating the included material with emerging strategies and treatments will provide therapists with the full range of skills needed to deal with and cope with this challenging problem.

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Howard A. Paul, Ph.D., F.A.Clin.P.
Fellow, American Academy of Clinical Psychology
Diplomat, American Board of Professional Psychology
Clinical Associate Professor, Dept. of Psychiatry
Robert Wood Johnson Medical School
University of Medicine and Dentistry of New Jersey
Private Practice 1 Wedgewood Drive.
North Brunswick, NJ 08902
paulha@umdnj.edu